

Case Number:	CM13-0044437		
Date Assigned:	01/15/2014	Date of Injury:	08/22/2003
Decision Date:	03/27/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is an 87-year-old female who reported an injury on 08/22/2003. The mechanism of injury was not specifically stated. The patient is currently diagnosed with neuropathic pain. The patient was seen by [REDACTED] on 10/01/2013. The patient reportedly increased left upper extremity pain. Physical examination revealed positive left Roos test, mild pectoralis tightness, 140 degree flexion, subacromial tenderness, AC joint tenderness, positive drop arm test, positive biceps roll test, positive Neer and Hawkins maneuver, decreased range of motion of bilateral wrists, and tenderness noted with positive Finkelstein's testing. Treatment recommendations included continuation of current medication as well as 6 sessions of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Physical therapy two (2) times a week for three (3) weeks for the left shoulder.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength,

endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient's injury was greater than 10 years ago to date. Documentation of a previous course of physical therapy was not provided. The patient has been instructed in and is compliant with an independent exercise program. Without documentation of functional improvement following a previous course of therapy, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.